October 26, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Oversight and Evaluation of the Fiscal Year 2008 Payment Error Rate Measurement Program (A-06-09-00037)

The attached final report provides the results of our review of our oversight and evaluation of the fiscal year (FY) 2008 Payment Error Rate Measurement (PERM) program. The Centers for Medicare & Medicaid Services (CMS) developed the PERM program to comply with the Improper Payments Information Act of 2002, P.L. No. 107-300, and Office of Management and Budget requirements for measuring improper Medicaid program and Children's Health Insurance Program (CHIP) payments. CMS's PERM program measures improper payments made in the fee-for-service, managed care, and eligibility components of Medicaid in FY 2008 and will measure improper payments under Medicaid and CHIP in future years.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through email at Joe.Green@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-06-09-00037 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

OVERSIGHT AND EVALUATION OF THE FISCAL YEAR 2008 PAYMENT ERROR RATE MEASUREMENT PROGRAM

Daniel R. Levinson
Inspector General

October 2010
A-06-09-00037

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Improper Payments Information Act of 2002 (IPIA) requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. In addition, for any program or activity with estimated improper payments exceeding $10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments. Section 2(f) of the IPIA requires the Director of the Office of Management and Budget (OMB) to prescribe guidance on implementing IPIA requirements.

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid program and Children's Health Insurance Program (CHIP) payments. CMS's PERM program measures improper payments made in the fee-for-service (FFS), managed care, and eligibility components of Medicaid in fiscal year (FY) 2008 and will measure improper payments under Medicaid and CHIP in future years.

Four contractors were responsible for operating the FY 2008 PERM program: two statistical contractors, a documentation/database contractor, and a review contractor.

OBJECTIVE

Our objective was to determine whether the States' Medicaid FFS and managed care universes for the FY 2008 PERM program were complete and accurate.

SUMMARY OF FINDINGS

State One did not maintain hospital information on a claim-by-claim basis, and we were not able to reconcile the State universes from four other States to their Forms CMS-64. The States' Medicaid FFS and managed care universes for the FY 2008 PERM program were or may have been incomplete or inaccurate. As a result, CMS could not be assured that the PERM program produced a reasonable estimate of improper payments.

RECOMMENDATIONS

We recommend that CMS:

- require State One to maintain hospital payment information on a claim-by-claim basis for use in future PERM reviews and

- continue to work with the States, CMS Regional Offices, and statistical contractors on reconciling the PERM universes to State financial reports.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendations and discussed the corrective actions it has taken or plans to take in response. CMS's comments are included in their entirety as Appendix E.

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INTRODUCTION

BACKGROUND

Improper Payments Information Act of 2002

The Improper Payments Information Act of 2002 (IPIA), P.L. No. 107-300, requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. In addition, for any program activity with estimated improper payments exceeding $10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments. Pursuant to section 2(f) of the IPIA, the Director of the Office of Management and Budget (OMB) must prescribe guidance on implementing IPIA requirements.

Improper Payments Information Act of 2002 Implementation Guidance

Unless a written waiver is obtained from OMB, OMB Circular A-123, Appendix C, requires an agency to:

> Review all programs and activities and identify those which are susceptible to significant erroneous payments.… Obtain a statistically valid estimate of the annual amount of improper payments in programs and activities …. Implement a plan to reduce erroneous payments.… [and] Report estimates of the annual amount of improper payments in programs and activities and progress in reducing them.

In its *Implementation Guidance*, OMB identified the Medicaid program and the Children's Health Insurance Program (CHIP) as programs at risk for significant erroneous payments. OMB requires the Department of Health & Human Services (HHS) to report the estimated amount of improper payments for each program annually in its accountability report. For example, the fiscal year (FY) 2008 Medicaid improper payments totaled 8.7 percent, or $16.4 billion (Federal share), which was reported in the HHS *FY 2009 Agency Financial Report*, dated November 16, 2009, and the *Medicaid Payment Error Rate Measurement Final Report* for FY 2008, dated October 2009.

Payment Error Rate Measurement Program

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and OMB requirements for measuring improper Medicaid and CHIP payments.[1] CMS's PERM program measures improper payments made in the fee-for-service (FFS), managed care, and eligibility components of Medicaid and

[1] CMS issued the following rules to implement its PERM program: proposed rule, 69 Fed. Reg. 52620 (Aug. 27, 2004); interim final rule with comment period, 70 Fed. Reg. 58260 (Oct. 5, 2005); second interim final rule with comment period, 71 Fed. Reg. 51050 (Aug. 28, 2006); final rule, 72 Fed. Reg. 50490 (Aug. 31, 2007) (as codified at 42 CFR §§ 431.950–431.1002 and 42 CFR § 457.720); and proposed rule, 74 Fed. Reg. 34468 (July 15, 2009).

CHIP in FY 2008 and will measure improper payments under Medicaid and CHIP in future years.[2]

Payment Error Rate Measurement Program Process

Under the PERM process, Medicaid and CHIP are divided into three different components: FFS, managed care, and eligibility. Each component has separate universes, samples, and error estimates. The States are responsible for compiling the Medicaid and CHIP claims universes each quarter and the eligibility universes each month. CMS requires States[3] to submit quarterly to the statistical contractor one universe each for FFS and managed care. States compile PERM universe files from Medicaid Management Information Systems (MMIS) and other sources.[4] The statistical contractor selects a sample from each of the quarterly universes. CMS also requires each State to select a sample of Medicaid and CHIP eligibility case files to determine whether they were correctly approved or denied. The FFS sample size is designed to be 500 claims per year per State, and the managed care sample size is 250 claims per year per State. The eligibility sample is split between eligible case files (504) and ineligible case files (204).

CMS used four contractors for the FY 2008 PERM program: two statistical contractors, a documentation/database contractor, and a review contractor. The statistical contractors were responsible for collecting and stratifying State universe information,[5] selecting quarterly samples of claims[6] for each of the 17 sampled States, calculating the estimated amount of State and national Medicaid and CHIP improper payments, and writing the final PERM report for CMS. The documentation/database contractor was responsible for receiving the claim information from the States, requesting State Medicaid and CHIP policies, and requesting medical records from providers. The review contractor was responsible for using the policies and medical records obtained by the documentation/database contractor to perform medical and data processing reviews, resolving differences in State and review contractor determinations, working with States to reprice errors, providing determinations to the statistical contractor, and assisting the statistical contractor in writing the final PERM report.

[2] On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), P.L. No. 111-3, was enacted. CHIPRA requires a new final rule to implement changes to the PERM process for CHIP and states that the Secretary shall not calculate or publish a PERM error rate for CHIP until 6 months after the final rule is published in the Federal Register. A proposed rule was published at 74 Fed. Reg. 34468 (July 15, 2009), but the final rule has not been published. As a result, CMS stopped work on calculating a CHIP error rate for FY 2008.

[3] The "States" include all 50 States and the District of Columbia.

[4] States, unless the requirement is waived by the Secretary of HHS, are required to process Medicaid payments through an MMIS approved by the Secretary.

[5] In this report, we use the term "State universe" to refer to all of the claim information from which a State's samples were selected.

[6] The PERM sampling unit is the lowest separately priced unit on a beneficiary-specific claim. This is typically a line item. However, for some types of claims, such as those representing diagnostic-related groups, the lowest separately priced item is the claim itself. We refer to the sampling unit as a "claim" in this report.

Waiver on Selection of States

Pursuant to OMB Circular A-123, Appendix C, an agency is required to develop a statistically valid estimate of erroneous payments unless OMB grants specific written approval (i.e., a waiver). CMS obtained a waiver from OMB allowing CMS to use an alternate sampling methodology that would allow every State to participate in the PERM program only once over a 3-year period, resulting in 17 States' participating in the PERM program every year.

State Financial Reporting Requirements

The CMS *State Medicaid Manual*, section 2500, requires that the amounts reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) be actual expenditures and be in readily reviewable form. The information for Form CMS-64 expenditures is obtained from invoices, cost reports, eligibility records, and other sources. States should not claim estimated expenditure amounts on the Form CMS-64. CMS guidance on the Quarterly Children's Health Insurance Program Statement of Expenditures for Title XXI (Form CMS-21) is the same as for Form CMS-64.

In our review of the FY 2007 PERM program,[7] we found that the PERM universes from four States for two quarters did not reconcile to the Form CMS-64 or Form CMS-21. In the *PERM FFY 2009 Universe Data Submission Instructions*, CMS requires States to compare their quarterly PERM universes to Forms CMS-64 and CMS-21 from the two previous quarters to ensure that all applicable programs from all necessary data sources are included in their PERM universes. For FY 2009, CMS also requires the statistical contractor to reconcile each State's quarterly universe to that same quarter's Forms CMS-64 and CMS-21.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the States' Medicaid FFS and managed care universes for the FY 2008 PERM program were complete and accurate.

Scope

We reviewed the accuracy of four States' universes. We did not review the overall internal control structure of the PERM contractors, the States, or CMS, nor did we independently verify the error rate calculation. Because CMS stopped work on CHIP for the FY 2008 cycle, we did not perform any testing of CHIP.

We performed fieldwork at The Lewin Group (the statistical contractor), in Falls Church, Virginia, and Livanta, LLC (the statistical contractor), in Columbia, Maryland. We also performed fieldwork at the Washington Department of Social and Health Services in Olympia, Washington; Indiana Office of Medicaid Policy and Planning in Indianapolis, Indiana; Florida

[7] *Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program*, issued May 5, 2010 (A-06-08-00078).

Bureau of Quality Management in Tallahassee, Florida; and Nevada Division of Health Care Financing and Policy in Carson City, Nevada. We performed our fieldwork from April through September 2009.

Methodology

To accomplish our objective, we:

- met with CMS officials and PERM contractors to obtain an understanding of any changes in the PERM process and issues with States,
- reviewed documentation from the statistical contractor related to problems with one State's universe,
- met with officials of four States to obtain an understanding of the PERM process at the State level, and
- attempted to reconcile the four selected States' Forms CMS-64 to their State universes.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The States' Medicaid FFS and managed care universes for the FY 2008 PERM program were or may have been incomplete or inaccurate. As a result, CMS could not be assured that the PERM program produced a reasonable estimate of improper payments.

UNIVERSES MAY HAVE BEEN INCOMPLETE OR INACCURATE

One State did not submit a complete universe, and we were not able to reconcile the State universes from four States to their Forms CMS-64. Accordingly, the statistical contractor selected samples of paid claims from State paid-claims universes that were incomplete or may not have been complete and accurate. The statistical contractor attempted to reconcile each of the States' quarterly universes to the Forms CMS-64. Despite this effort by the statistical contractor, there were still unresolved differences between the PERM universes and the Forms CMS-64.

According to the *PERM FY 2008 Universe Data Submission Instructions*, the PERM universe[8] should have consisted of adjudicated or paid Medicaid and CHIP FFS and managed care claims

[8] For this report, we use the term "PERM universe" to refer to all claim information from all States to be sampled in a specific time period.

that were originally paid or denied payment from October 1, 2007, through September 30, 2008, and that involved Federal financial participation. If the States followed all guidance correctly, the PERM universe should have contained all Medicaid FFS and managed care payments, including those processed outside the States' payment systems. Each PERM universe should have included claims for which the States had no additional payment liability because, for example, a third party was liable or a Medicare payment exceeded the States' allowable charges.

State One

State One did not pay inpatient or outpatient hospitals on a claim-by-claim basis.[9] Rather, State One made weekly payments to hospitals based on expenditure data from previous years. State One's hospital payments accounted for approximately 21 percent of its Medicaid expenditures.

Because State One did not pay hospitals on a claim-by-claim basis, CMS excluded all of the State's hospital payments from State One's calculation of the PERM error rate. The error rate was based on the remaining 79 percent of the payments in State One's universe and was assumed to be the same for the hospital payments. State One's error rate was included in the national error rate.

State Two

We were not able to completely reconcile State Two's Medicaid universes to the Form CMS-64 data. Because we were unable to reconcile the Form CMS-64 data to the State Two universes, we discussed our reconciliation with State Two officials. State Two was unable to provide additional information to assist us in reconciling State Two's Form CMS-64 data to its universes and could not explain the differences. The differences we identified during the reconciliation attempt are shown in Appendix A.

State Three

We were not able to completely reconcile State Three's Medicaid universes to the Form CMS-64 data. Because we were unable to reconcile the Form CMS-64 data to the State Three universes, we discussed our reconciliation with State Three officials. Although State Three provided additional information, we still were unable to reconcile State Three's Form CMS-64 data to its universes. The differences we identified during the reconciliation attempt are shown in Appendix B.

State Four

We were not able to completely reconcile State Four's Medicaid universes to the Form CMS-64 data. Because we were unable to reconcile the Form CMS-64 data to the State Four universes, we discussed our reconciliation with State Four officials. We determined that State Four had incorrectly reported expenditures on the Form CMS-64 for the fourth quarter of FY 2008 as a result of implementing a new payment system. Although State Four and CMS provided

[9] Because this State did not submit a complete universe, we did not attempt a reconciliation of its universes to the Form CMS-64.

additional information on how the fourth-quarter expenditures were reported and adjusted in subsequent quarters, we still were unable to reconcile State Four's Form CMS-64 data to its universes. The differences we identified during the reconciliation attempt are shown in Appendix C.

State Five

We were not able to completely reconcile State Five's Medicaid universes to the Form CMS-64 data. Because we were unable to reconcile the Form CMS-64 data to the State Five universes, we discussed our reconciliation with State Five officials. Although State Five provided additional information, we still were unable to reconcile State Five's Form CMS-64 data to its universes. The differences we identified during the reconciliation attempt are shown in Appendix D.

RECOMMENDATIONS

We recommend that CMS:

- require State One to maintain hospital payment information on a claim-by-claim basis for use in future PERM reviews and

- continue to work with the States, CMS Regional Offices, and statistical contractors on reconciling the PERM universes to State financial reports.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendations and discussed the corrective actions it has taken or plans to take in response. CMS's comments are included in their entirety as Appendix E.

APPENDIXES

APPENDIX A: STATE TWO RECONCILIATION

Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid FFS 1st Quarter	Medicaid FFS 2nd Quarter	Medicaid FFS 3rd Quarter	Medicaid FFS 4th Quarter	Medicaid FFS Total
State universe	$1,068,186,881	$1,070,076,843	$1,078,277,222	$1,095,859,366	$4,312,400,311
Form CMS-64 amounts	$1,105,414,199	$1,127,548,434	$1,084,179,975	$1,110,202,308	$4,427,344,916
Difference	($37,227,318)	($57,471,591)	($5,902,753)	($14,342,942)	($114,944,605)
Difference as a percentage of Form CMS-64 amounts	(3.4%)	(5.1%)	(0.5%)	(1.3%)	(2.6%)

Managed Care Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid Managed Care 1st Quarter	Medicaid Managed Care 2nd Quarter	Medicaid Managed Care 3rd Quarter	Medicaid Managed Care 4th Quarter	Medicaid Managed Care Total
State universe	$451,022,583	$381,002,986	$391,861,458	$311,977,517	$1,535,864,544
Form CMS-64 amounts	$432,036,948	$363,019,874	$311,614,049	$372,034,506	$1,478,705,377
Difference	$18,985,635	$17,983,112	$80,247,409	($60,056,989)	$57,159,167
Difference as a percentage of Form CMS-64 amounts	4.4%	5.0%	25.8%	(16.1%)	3.9%

Combined Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid 1st Quarter	Medicaid 2nd Quarter	Medicaid 3rd Quarter	Medicaid 4th Quarter	Medicaid Total
State universe	$1,519,209,465	$1,451,079,829	$1,470,138,680	$1,407,836,882	$5,848,264,856
Form CMS-64 amounts	$1,537,451,147	$1,490,568,308	$1,395,794,024	$1,482,236,814	$5,906,050,293
Difference	($18,241,682)	($39,488,479)	$74,344,656	($74,399,932)	($57,785,437)
Difference as a percentage of Form CMS-64 amounts	(1.2%)	(2.6%)	5.3%	(5.0%)	(1.0%)

CMS = Centers for Medicare & Medicaid Services
FFS = fee-for-service

APPENDIX B: STATE THREE RECONCILIATION

Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid FFS 1st Quarter	Medicaid FFS 2nd Quarter	Medicaid FFS 3rd Quarter	Medicaid FFS 4th Quarter	Medicaid FFS Total
State universe	$944,145,820	$922,764,239	$940,758,758	$996,227,991	$3,803,896,807
Form CMS-64 amounts	$1,049,702,421	$942,811,603	$1,112,771,698	$982,854,799	$4,088,140,521
Difference	($105,556,601)	($20,047,364)	($172,012,940)	$13,373,192	($284,243,714)
Difference as a percentage of Form CMS-64 amounts	(10.1%)	(2.1%)	(15.5%)	1.4%	(7.5%)

Managed Care Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid Managed Care 1st Quarter	Medicaid Managed Care 2nd Quarter	Medicaid Managed Care 3rd Quarter	Medicaid Managed Care 4th Quarter	Medicaid Managed Care Total
State universe	$259,280,724	$265,701,773	$278,676,999	$295,020,508	$1,098,680,005
Form CMS-64 amounts	$280,273,318	$271,347,565	$285,563,245	$305,027,620	$1,142,211,748
Difference	($20,992,594)	($5,645,792)	($6,886,246)	($10,007,112)	($43,531,743)
Difference as a percentage of Form CMS-64 amounts	(7.5%)	(2.1%)	(2.4%)	(3.3%)	(4.0%)

Combined Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid 1st Quarter	Medicaid 2nd Quarter	Medicaid 3rd Quarter	Medicaid 4th Quarter	Medicaid Total
State universe	$1,203,426,544	$1,188,466,012	$1,219,435,757	$1,291,248,499	$4,902,576,812
Form CMS-64 amounts	$1,329,975,739	$1,214,159,168	$1,398,334,943	$1,287,882,419	$5,230,352,269
Difference	($126,549,195)	($25,693,156)	($178,899,186)	$3,366,080	($327,775,457)
Difference as a percentage of Form CMS-64 amounts	(9.5%)	(2.1%)	(12.8%)	0.3%	(6.3%)

APPENDIX C: STATE FOUR RECONCILIATION

Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid FFS 1st Quarter	Medicaid FFS 2nd Quarter	Medicaid FFS 3rd Quarter	Medicaid FFS 4th Quarter	Medicaid FFS Total
State universe	$2,440,865,758	$2,418,369,272	$2,451,105,566	$2,099,138,099	$9,409,478,694
Form CMS-64 amounts	$2,622,151,779	$2,889,740,920	$2,835,158,359	$2,689,801,661	$11,216,852,719
Difference	($181,286,021)	($471,371,648)	($384,052,793)	($770,663,562)	($1,807,374,025)
Difference as a percentage of Form CMS-64 amounts	(6.9%)	(16.3%)	(13.6%)	(26.9%)	(16.1%)

Managed Care Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid Managed Care 1st Quarter	Medicaid Managed Care 2nd Quarter	Medicaid Managed Care 3rd Quarter	Medicaid Managed Care 4th Quarter	Medicaid Managed Care Total
State universe	$620,761,361	$618,716,093	$836,044,609	$419,420,461	$2,494,942,523
Form CMS-64 amounts	$618,233,619	$684,735,119	$834,359,405	$600,814,534	$2,738,142,677
Difference	$2,527,742	($66,019,026)	$1,685,204	($181,394,073)	($243,200,154)
Difference as a percentage of Form CMS-64 amounts	0.4%	(9.6%)	0.2%	(30.2%)	(8.9%)

Combined Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid 1st Quarter	Medicaid 2nd Quarter	Medicaid 3rd Quarter	Medicaid 4th Quarter	Medicaid Total
State universe	$3,061,627,119	$3,037,085,364	$3,287,150,175	$2,518,558,560	$11,904,421,218
Form CMS-64 amounts	$3,240,385,398	$3,574,476,039	$3,669,517,764	$3,470,616,195	$13,954,995,396
Difference	($178,758,279)	($537,390,675)	($382,367,589)	($952,057,635)	($2,050,574,178)
Difference as a percentage of Form CMS-64 amounts	(5.5%)	(15.0%)	(10.4%)	(27.4%)	(14.7%)

APPENDIX D: STATE FIVE RECONCILIATION

Fee-for-Service Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid FFS 1st Quarter	Medicaid FFS 2nd Quarter	Medicaid FFS 3rd Quarter	Medicaid FFS 4th Quarter	Medicaid FFS Total
State universe	$250,812,935	$243,832,036	$239,335,661	$277,451,595	$1,011,432,227
Form CMS-64 amounts	$238,409,275	$229,911,597	$228,855,893	$264,926,868	$962,103,634
Difference	$12,403,660	$13,920,439	$10,479,768	$12,524,727	$49,328,593
Difference as a percentage of Form CMS-64 amounts	5.2%	6.1%	4.6%	4.7%	5.1%

Managed Care Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid Managed Care 1st Quarter	Medicaid Managed Care 2nd Quarter	Medicaid Managed Care 3rd Quarter	Medicaid Managed Care 4th Quarter	Medicaid Managed Care Total
State universe	$43,819,697	$45,830,963	$44,316,187	$47,288,870	$181,255,717
Form CMS-64 amounts	$44,096,576	$45,515,215	$43,726,309	$48,338,155	$181,676,254
Difference	($276,879)	$315,748	$589,878	($1,049,285)	($420,537)
Difference as a percentage of Form CMS-64 amounts	(0.6%)	0.7%	1.4%	(2.2%)	(0.2%)

Combined Amounts Reported for the Payment Error Rate Measurement Program and on Form CMS-64 for Fiscal Year 2008

	Medicaid 1st Quarter	Medicaid 2nd Quarter	Medicaid 3rd Quarter	Medicaid 4th Quarter	Medicaid Total
State universe	$294,632,632	$289,662,999	$283,651,848	$324,740,465	$1,192,687,944
Form CMS-64 amounts	$282,505,851	$275,426,812	$272,582,202	$313,265,023	$1,143,779,888
Difference	$12,126,781	$14,236,187	$11,069,646	$11,475,442	$48,908,056
Difference as a percentage of Form CMS-64 amounts	4.3%	5.2%	4.1%	3.7%	4.3%

APPENDIX E: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 0 7 2010

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Oversight and Evaluation of the Fiscal Year 2008 Payment Error Rate Measurement Program" (A-06-09-00037)

Thank you for the opportunity to comment on the OIG draft report titled, "Oversight and Evaluation of the Fiscal Year (FY) 2008 Payment Error Rate Measurement (PERM) Program" (A-06-09-00037). We appreciate the OIG's review of the PERM program and its recommendations for program improvement. We have reviewed the report and have responded to your recommendations.

OIG Recommendation

Require State One to maintain hospital payment information on a claim-by-claim basis for use in future PERM reviews.

CMS Response

The Centers for Medicare & Medicaid Services (CMS) concurs that State One[1] should maintain hospital payment information on a claim-by-claim basis. The statistical methodology for the PERM program specifies that PERM universes should include only payments made on behalf of individual beneficiaries. Aggregate payments are specifically excluded from the PERM sampling frame. State One paid all in-state hospitals for inpatient and outpatient services through weekly prospective interim payments (PIPs), lump sum payments based on each hospital's historical aggregate payment information, and periodically cost settled the difference between the allowed amounts and the sum of the PIPs. Although some beneficiary-level data was submitted on "claims," it was not possible to determine the dollar amount in error associated with these records because there was no paid amount, and the allowed amount was unreliable for outpatient services. Since only individual, beneficiary-level payments are included in the PERM sampling frame and PERM errors must affect payment, CMS excluded State

[1] State One refers to an unnamed State reviewed by the OIG.

One's in-state hospital inpatient and outpatient payments from the State's calculation of the FY 2008 PERM error rate.

To help prevent such issues from surfacing in future PERM cycles, CMS formed a State systems workgroup for collaboration with CMS and the States to address State systems problems, such as benefit information not being stored electronically, information not being stored at the beneficiary level, and to discuss any other impediments to the measurement process. CMS began this workgroup with a focus on States that participated in the FY 2007 and FY 2008 cycles and intends to utilize it for subsequent cycles. Through this workgroup, CMS spoke with State One about their PIP payments to in-state hospitals. Subsequent to the FY 2008 PERM cycle, State One implemented a new Medicaid Management Information System which changes the way their hospitals are reimbursed. The State's hospitals are in the process of transitioning away from PIP payments to a method of reimbursement that will fit into the PERM sampling frame. The transition will be occurring throughout the upcoming cycle and is scheduled to be complete in January 2012.

To address State One's hospital payments which will not transition in time for the FY 2011 cycle and for numerous other aggregate payments made by States which do not fit under the current PERM sampling frame, CMS is developing an aggregate payment methodology. This aggregate payment methodology will allow States, when appropriate, to submit aggregate payments in the PERM universe for sampling and review and CMS to include many more aggregate payments in the PERM measurement. CMS is currently piloting this methodology and plans to incorporate it into the FY 2011 error rate measurement which will start at the end of 2010 and conclude in 2012.

OIG Recommendation

Continue to work with the States, CMS Regional Offices, and statistical contractor on reconciling the PERM universes to State financial reports.

CMS Response

The CMS concurs and has implemented a two-stage reconciliation process beginning with the FY 2009 PERM cycle to ensure that States' PERM universes are complete and accurate. The two-stage reconciliation process compares States' quarterly universe data submission to the financial reports, forms CMS-64 and CMS-21. In the first stage, CMS asks States to compare their quarterly universe data submission to the previous two quarters of these forms. The previous two quarters of these forms are used because the PERM universe data submissions are required prior to the time these reports are finalized. The first stage of this two-stage reconciliation allows States to identify, prior to universe data submission, sources of incomplete or inaccurate universe data. The second stage is a comparison, by the statistical contractor, of the current quarter's universe data with the current quarter's forms CMS-64 and CMS-21. In both stages of the reconciliation, large differences between universe data and these reports are examined.

Implementing this two-stage process has proven beneficial to conducting FY 2009 reconciliations. First, in FY 2008, Financial Management Reports were used to reconcile PERM universes instead of the forms CMS-64 and CMS-21. Using the CMS-64 and CMS-21 forms in FY 2009 has allowed CMS to reconcile at a more detailed level and identify potential missing data. In addition, the two-stage process has resulted in States being more actively involved in reconciling PERM universes to financial reports. Many States now involve financial staff when creating PERM universes to ensure all Medicaid and CHIP programs matched with federal funds are submitted for review. CMS intends to continue to utilize and improve this reconciliation process in subsequent PERM measurement cycles. For example, in the FY 2010 cycle CMS provided States with reconciliation guidelines and a template to assist States with the first reconciliation stage.

The CMS appreciates the opportunity to review and comment on this OIG report and looks forward to strengthening the PERM process.